Medical Assistance Provider Bulletin

Attention: All Title XIX Community Care Organizations

Subject: New Claim Form; Place of Service, Type of Service and HCPCS Codes

Date: September 1, 1987

Code: MAPB-087-005-0

TABLE OF CONTENTS

This bulletin contains important information on the following:

This bulletin should be used in conjunction with the All Provider Bulletin, MAPB-087-037-X, dated September 1, 1987.

I. INTRODUCTION

The Wisconsin Medical Assistance Program (WMAP) has signed a new fiscal agent contract with E.D.S. Federal Corporation (EDS). Under this new contract, there will be major enhancements in the processing of Medical Assistance claims received by EDS on or after January 1, 1988. These enhancements are discussed in detail in the above referenced All Provider Bulletin.

In addition to the changes resulting from the new contract with EDS, the Health Care Financing Administration (HCFA) has mandated that all State Medical Assistance agencies implement use of a new claim form, the National Health Insurance Claim Form, HCFA 1500. The WMAP is implementing use of the National HCFA 1500 claim form for most providers. Many providers already use the Wisconsin version of the HCFA 1500 claim form to bill the WMAP and some are using the National HCFA 1500 claim form to bill Medicare and other third party payors. To facilitate consistent billing procedures, the WMAP is implementing the National HCFA 1500 claim form and national and local Place of Service and Type of Service codes.

Concurrent with the claim form change, the WMAP is also implementing the HCFA Common Procedure Coding System (HCPCS) currently used by Medicare. Use of HCPCS codes is also federally mandated.

NOTE: Due to the above mentioned changes, EDS will be converting the claims processing system at the end of 1987. Providers are advised to submit to EDS for receipt by no later than December 24, 1987, all claims, adjustments and prior authorization requests which are completed in accordance with billing instructions and claim forms in use in 1987. EDS will return, unprocessed, any claims received after December 24 which are in the 1987 format.

Past experience has shown that delivery of claims mailed during the holiday season is delayed due to heavy holiday mail. Please allow ample mailing time to ensure that claims mailed in 1987 are received no later than December 24. If there is a likely possibility that claims prepared and mailed in late December will not be received by EDS by December 24, it may be to the provider's advantage to hold such claims and mail them in the new format on or after January 1, 1988.

Providers are also advised that no checks will be issued on January 3, 1988. Claims which would have finalized processing during that week will appear on the following week's Remittance and Status Report.

II. PROVIDER BILLING WORKSHOPS

EDS is conducting provider workshops which focus on the WMAP requirements for the National HCFA 1500 claim form. These workshops are intended for billing personnel. See Attachment 5 for time and locations in your area.

III. NATIONAL HEALTH INSURANCE CLAIM FORM - HCFA 1500

All Community Care Organizations are required to use the National HCFA 1500 claim form for all claims received by EDS on or after January 1, 1988. Claims, including resubmission of any previously denied claims, received on a form other than the National HCFA 1500 claim form will be denied by E.D.S. Federal Corporation. Modifications to or use of modified versions of the National HCFA 1500 claim form may also result in claims denial.

A sample claim form and detailed billing instructions are included in Attachments 1 and 2 of this bulletin. Providers should pay special attention to the following areas on the National HCFA 1500 claim form itself and to the changes in the type of information required for completion of the claim form.

1. Program Block (Claim Sort Indicator). A new element, the claim sort indicator, must be entered in the program block for Medicaid which is located on the top line of the claim form. This indicator identifies the general kinds of services being billed and is essential to processing of the claim form by EDS. Claim sort indicators for each type of service are included in the billing instructions. The sample claim form included in Attachment 1 indicates where on the claim form this information is to be entered. Claims received on or after January 1, 1988 without this claim sort indicator will be denied.

2. Element 1. The recipient's last name is required first, then the first name, and middle initial.

3. Element 6. The 10 digit Medical Assistance Recipient Identification Number must be entered.

4. Element 9. Revised "Other Insurance" (OI) disclaimer codes, identified in the claim form completion instructions, must be entered in this element.

5. Element 10. This is an addition to the element which requests "other" accident information.

6. Element 11. Medicare disclaimer codes, identified in the claim form completion instructions, must be entered in this element.

7. Element 24. There are two (2) fewer line items than on the current HCFA 1500 claim form.

8. Element 24H. Recipient spenddown amount, when applicable, must be entered in this element.

Providers should reference the All Provider Bulletin, MAPB-087-037-X, dated September 1, 1987, for additional details on claims processing changes.

Effective January 1, 1988, the National HCFA 1500 claim form will not be provided by either the WMAP or EDS. It is a national form and may be obtained at the provider's expense from a number of forms suppliers and other sources. One such source is:

State Medical Society Services, Inc.
P.O. Box 1109
MADISON WI 53701

(608) 257-6781 (Madison area)
1-800-362-9080 (Toll free)

IV. PLACE OF SERVICE CODES

Claims received by EDS on or after January 1, 1988 must include national place of service (POS) codes in element #24B on the National HCFA 1500 claim form. Claims/adjustments submitted without POS codes or with incorrect POS codes will be denied. POS codes are listed on the back of the claim form. The allowable POS code for Community Care Organizations is included in Attachment 4.

V. TYPE OF SERVICE CODES

Effective January 1, 1988, the WMAP is converting currently used type of service (TOS) codes to coincide with the National TOS codes, which are located on the back of the National HCFA 1500 claim form, and with the additional codes used by Medicare and the WMAP. All providers are required to indicate the appropriate TOS code in element #24G on the claim form for each line item billed on all claims received on or after January 1, 1988. Claims/adjustments submitted without TOS codes will be denied. Claims/adjustments submitted with incorrect TOS codes are subject to incorrect reimbursement or denial. The allowable TOS code for Community Care Organizations is included in Attachment 4.

VI. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

The Health Care Financing Administration has also mandated state Medical Assistance agencies to use HCPCS. HCPCS is a procedure coding system that is currently used by Medicare.

HCPCS codes are composed of:

- Physician's Current Procedural Terminology - Fourth Edition (CPT-4) codes which are updated annually;
- Nationally assigned codes which are five (5) characters in length (alpha/numeric) and begin with any of the alpha characters A through V, e.g., A1234 - V5678; and
- Codes locally assigned by the WMAP or the Medicare Intermediary which are five (5) characters in length (alpha/numeric), and begin with the alpha characters W through Z, e.g., W1111 - Z9999.

HCPCS codes and their narrative descriptions are required on all claims/adjustments received by EDS on or after January 1, 1988. Claims/adjustments submitted without HCPCS codes and narrative descriptions will be denied. The allowable HCPCS code and its description for Community Care Organizations is included in Attachment 3.

ATTACHMENTS
CCO SERVICES

Page No.

Community Care Services

FORM APPROVED
OMB NO 0938-0008

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

[ ] MEDICARE (MEDICARE NO.) [M] MEDICAID (MEDICAID NO.) [ ] CHAMPUS (SPONSOR'S SSN) [ ] CHAMPVA (VA FILE NO.) [ ] FECA BLACK LUNG (SSN) [ ] OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Recipient Im A.

2 PATIENT'S DATE OF BIRTH: MM | DD | YY

3 INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Same

4 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown WI 53725

TELEPHONE NO

5 PATIENT'S SEX: MALE [X] FEMALE [ ]

6 INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS): 1234567890

7 PATIENT'S RELATIONSHIP TO INSURED: SELF [X] SPOUSE [ ] CHILD [ ] OTHER [ ]

8 INSURED'S GROUP NO (OR GROUP NAME OR FECA CLAIM NO.)

[ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9 OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER): OI - D

10 WAS CONDITION RELATED TO

A PATIENT'S EMPLOYMENT: YES [ ] [X] NO

B ACCIDENT: AUTO [ ] [ ] OTHER

11 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE): M - 8

TELEPHONE NO

11a CHAMPUS SPONSOR'S STATUS: [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED — BRANCH OF SERVICE

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW

SIGNED / DATE / / / / / / / /

13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW

SIGNED (INSURED OR AUTHORIZED PERSON) / / / / / / / / /

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ◄ ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES / / / / / / / / / / /

16a IF EMERGENCY CHECK HERE [ ]

17 DATE PATIENT ABLE TO RETURN TO WORK / / / / / / / /

18 DATES OF TOTAL DISABILITY FROM / / / / / / / / / / THROUGH / / / / / / / / / / /

DATES OF PARTIAL DISABILITY FROM / / / / / / / / / THROUGH / / / / / / /

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED — DISCHARGED

21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] [ ] NO CHARGES

23 A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE

1 V68.9 Unspecified Encounter for Administrative Purposes
2
3
4

B EPSDT YES [ ] [ ] NO
FAMILY PLANNING YES [ ] [ ] NO

PRIOR AUTHORIZATION NO

24 A DATE OF SERVICE FROM TO	B* PLACE OF SERVICE	C PROCEDURE CODE (IDENTIFY)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G* TOS	H LEAVE BLANK
02/01-29/88	0	W6300	CCO Administrative Fee		XX XX	29	9	
								Patient Spenddown $

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)

DATE MM/DD/YY I.M. PROVIDER

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) / / / YES [ ] / [ ] NO / /

27 TOTAL CHARGE: XX XX

28 AMOUNT PAID: XX XX

29 BALANCE DUE: XX.XX

30 YOUR SOCIAL SECURITY NO

31 PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO

I.M. Billing
1 W Williams
Anytown WI 53725

I.D. NO 87654321

32 YOUR PATIENT'S ACCOUNT NO: 1234JED

33 YOUR EMPLOYER I.D. NO / / / / / / / / / / / /

*PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (C-2) (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

790 00

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR COMMUNITY CARE ORGANIZATIONS

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To avoid unnecessary denial or inaccurate claim payment, providers must utilize the following claim form completion instructions. Enter all required data on the face of the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless 'optional' or 'not required' is specified.

Wisconsin medical assistance recipients receive a medical assistance ID card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. This card should always be presented prior to rendering the service. Please use the information exactly as it appears on the ID card to complete the Patient and Insured (subscriber) Information section.

Program Block/Claim Sort Indicator
Enter the appropriate **CLAIM SORT INDICATOR** for the service billed in the Medicaid check box in the upper left-hand corner of the claim form. Claims submitted without this indicator are denied.

'D' - Corrective Shoes
- Durable Medical Equipment (unless dispensed by a therapist)
- Hearing Aids

'M' - Independent Nurse
- Mental Health - 51.42 Board Operated AODA, Day Treatment, Psychotherapy
- Nurse Midwife
- Rehabilitation Agency
- Community Care Organization

'P' - Chiropractor
- Family Planning

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'P' - Free Standing Ambulatory Surgery Center
- Independent Laboratory and Radiology
- Mental Health - Non-51.42 Board Operated AODA, Day Treatment, Psychotherapy
- Physician
- Rural Health Agency

'T' - Therapy - Occupational, Physical, Speech and Hearing
- Durable Medical Equipment Dispensed by Occupational, Physical or Speech Therapist

'V' - Vision - Optometrist, Optician, Dispensing Ophthalmologist

ELEMENT 1 - PATIENT NAME
Enter the recipient's last name, first name and middle initial as it appears on his/her current medical assistance identification card.

ELEMENT 2 - PATIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., January 5, 1978 would be 01/05/78) as it appears on his/her medical assistance identification card.

ELEMENT 3 - INSURED'S NAME
If the recipient's name (element #1) and insured's name (element #3) are the same, enter 'SAME' or leave the element blank. When billing for a newborn, enter the mother's last name, first name, middle initial and date of birth in MM/DD/YY format.

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NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
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ELEMENT 4 - PATIENT'S ADDRESS
Enter the complete address of the recipient's place of residence; if the recipient is a resident of a nursing home, enter the name and address of the nursing home.

ELEMENT 5 - PATIENT'S SEX
Specify if male or female with an 'X'.

ELEMENT 6 - INSURED'S ID NUMBER
Enter the recipient's ten digit medical assistance ID number as found on his/her medical assistance identification card.

ELEMENT 7 - PATIENT'S RELATIONSHIP TO INSURED (not required)

ELEMENT 8 - INSURED'S GROUP NUMBER (not required)

ELEMENT 9 - OTHER INSURANCE
Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP if the service is one of those identified in the Billing Information section of the WMAP Provider Handbook, Part A. When the recipient's medical assistance card indicates other coverage, one of the following codes MUST be indicated. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID by other insurance
OI-D	DENIED by other insurance, benefits exhausted, deductible not reached, non-covered service, etc.
OI-C	Recipient or other party will NOT COOPERATE
OI-S	SENT claim, but insurance company did not respond
OI-R	RECIPIENT denies coverage

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
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OI-E	ERISA plan denies being prime
OI-A	Benefits NOT ASSIGNABLE
OI-H	Denied payment. Private health maintenance organization (HMO) or health maintenance plan (HMP) denied payment due to one of the following: non-covered/family planning service, or paid amount applied to the recipient's coinsurance/deductible.

If the recipient's medical assistance card indicates no other coverage, the element may be left blank.

ELEMENT 10 - IS CONDITION RELATED TO
If the condition is the result of an employment-related, auto or other accident, enter an 'X' in the appropriate box for items 'A' and 'B'.

ELEMENT 11 - INSURED'S ADDRESS
This element is used by the WMAP for Medicare information. Medicare must be billed prior to the WMAP. When the recipient's medical assistance card indicates Medicare coverage, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted
M-5	Provider not Medicare certified
M-6	Recipient not Medicare eligible
M-7	Service denied/rejected by Medicare
M-8	Not a Medicare benefit

If the recipient's medical assistance card indicates no Medicare coverage, this element may be left blank.

ELEMENT 11A - (not required)

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
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ELEMENTS 12 - 13
(Not required, provider automatically accepts assignment through medical assistance certification.)

ELEMENT 14 - DATE OF ILLNESS OR INJURY (not required)

ELEMENT 15 - DATE FIRST CONSULTED FOR CONDITION (not required)

ELEMENT 16 - (not required)

ELEMENT 16A - EMERGENCY
Enter an 'X' if emergent.

ELEMENT 17 - (not required)

ELEMENT 18 - (not required)

ELEMENT 19 - REFERRING PHYSICIAN (not required)

ELEMENT 20 - HOSPITALIZATION DATES (not required)

ELEMENT 21 - NAME AND ADDRESS OF FACILITY (not required)

ELEMENT 22 - LAB WORK, PLACE OF SERVICE (not required)

ELEMENT 23A - DIAGNOSIS
Diagnosis code V68.9 - Unspecified Encounter for Administrative Purposes must be entered.

ELEMENT 23B - EPSDT/FAMILY PLANNING INDICATOR/PRIOR AUTHORIZATION NUMBER
(not required)

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR COMMUNITY CARE ORGANIZATIONS

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ELEMENT 24 - SERVICES

Element 24A - Date of Service

Enter the FROM and TO dates of service in MMDDYY format in column A.

Element 24B - Place of Service

Enter the appropriate place of service code in column B for each service. Refer to Attachment 4 of this bulletin for a list of allowable place of service codes for Community Care Organizations.

Element 24C - Procedure Code and Description

Enter the appropriate procedure code and matching description for each service performed. Refer to Attachment 3 of the bulletin for a list of allowable procedure codes/descriptions for Community Care Organizations.

Element 24D - Diagnosis Code Reference (not required)

Element 24E - Charges

Enter the total charge for that month.

Element 24F - Days or Units

Enter the total number of days being billed per month.

Element 24G - Type of Service (TOS)

Enter the appropriate type of service code. Refer to Attachment 4 of this bulletin for a list of allowable type of service codes for Community Care Organizations.

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Element 24H - Recipient Spenddown

Enter the spenddown amount, when applicable, on the last detail line of element 24H directly above element 29. Refer to MAPB-087-037-X dated September 1, 1987 for information on recipient spenddown.

ELEMENT 25 - PROVIDER SIGNATURE AND DATE

The provider or the authorized representative must sign in element 25. The month, day and year the form is signed must also be entered.

NOTE: This may be a computer printed name and date, or a signature stamp.

ELEMENT 26 -

(Not required, provider automatically accepts assignment through medical assistance certification.)

ELEMENT 27 - TOTAL CHARGE

Enter the total charges for this claim.

ELEMENT 28 - AMOUNT PAID

Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00.

ELEMENT 29 - BALANCE DUE

Enter the balance due as determined by subtracting the amount in element 24H and element 28 from the amount in element 27.

ELEMENT 30 - (not required)

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ELEMENT 31 - PROVIDER NAME AND ID NUMBER

Enter the name, address, city, state and zip code of the billing provider. At the bottom of element 31 enter the billing provider's eight digit provider number.

ELEMENT 32 - PATIENT ACCOUNT NUMBER

Optional - provider may enter the patient's internal office account number. This number will appear on the EDS Remittance and Status Report (maximum of twelve characters).

ELEMENT 33 - (not required)

ATTACHMENT 3

COMMUNITY CARE ORGANIZATION SERVICES

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HCPCS PROCEDURE CODE AND COPAYMENT CONVERSION TABLE FOR COMMUNITY CARE ORGANIZATION (CCO) SERVICES

The new HCFA Common Procedure Code System (HCPCS) is required for claims submitted on and after January 1, 1988. Please refer to the following table.

Prior to 01/01/88	Effective 01/01/88	Mod	New Description	Copayment
05000	W6300	n/a	CCO Administrative Fee	n/a

ATTACHMENT 4

COMMUNITY CARE ORGANIZATION SERVICES

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PLACE OF SERVICE (POS) CONVERSION TABLE

Prior to 01/01/88	Effective 01/01/88	New Description
9	ø	Other

TYPE OF SERVICE (TOS) CONVERSION TABLE

Prior to 01/01/88	Effective 01/01/88	New Description
9	9	Other - CCO Services